

Authorization for Use and Disclosure of Protected Health Information



Patient Identification

Printed Name: _____ Date of Birth: _____
 Address: _____
 Social Security #: _____ Telephone: (____) _____

Information to be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Radiology reports/images	<input type="checkbox"/> Cardiac imaging
<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> Complete billing record	<input type="checkbox"/> Itemized bill
<input type="checkbox"/> Discharge instructions	<input type="checkbox"/> Pulmonary function results	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Release of Information (ROI) Abstract - History & physical (H&P), Discharge Summary, Labor & Delivery Note, Operative Report, Procedure Note, Consultation, laboratory, Pathology, X-ray reports		

Other (specify) _____

Purpose of Request

<input type="checkbox"/> Treatment of consultation	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Billing or claims payment
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Other (specify) _____

Send / Release Information

Paper CD Electronic Portal (E-mail notification when access is available)

***Please initial if you have requested your information to be sent to you in an unencrypted electronic format.** _____

Release to Name: _____

Mail to Name: _____

Mail to Address: _____

E-mail Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and/or psychiatric treatment I have been afforded the opportunity to sign a specific authorization. **Initial One: Yes** ____ **No** ____ **Not Applicable** ____

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.

Initial One: Yes ____ **No** ____ **Not Applicable** ____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer: Deborah Stewart at CHRISTUS Good Shepherd Health System, 700 E. Marshall Ave, Longview, TX 75601, or email dstewart@gsmc.org. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize CHRISTUS Good Shepherd Health System to release the protected health information specified above.

Signature: _____ Date: _____

Authority of Personal Representative to Request Disclosure: _____

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____

Verified by: _____

Effective Date: 02/01/17